Reset Form

Release of Information

Effective Date		Author	

General

Authorization for the Disclosure of Protected Health Information

By signing this form below, I am authorizing the disclosure of my protected health information to one or more persons for the purposes specified on this form. If I agree, I understand this may include information about any substance use disorder treatment I have received.

Release To/Obtain From

Name or other specific identification of person(s) authorized to receive/make the requested use or disclosure:

☐ Organization/Provider ☐ Personal Contact Type: ☐ Release To ☐Obtain From

Release To/From					
Contact Type (check one)	☐Organization/Provider ☐Personal Contact				
Organization					
Name					
Address					
City		State		Zip	
Phone		Fax Number			

Purpose of Disclosure

☐ Process of insurance/third party claims ☐ Quality Improvement	☐ Treatment /Care Coordination ☐ Other:

Expiration

If nothing is marked, the authorization will expire one (1) year from date signed. If you would like to specify a different expiration date, then do so by selecting one of the alternative options below or using the “end date” box below.

☐ 1 time disclosure ☐ 6 months ☐ End of Agency Treatment

Start Date		End Date	

Information to be Disclosed

ROI Type (check one): ☐General ☐MH ☐SUD

☐ All Records
☐ Intake/Admission Information
☐ Discharge Summary/Plan
☐ School Records / Reports / IEPs
☐ Progress Notes
☐ Acknowledgement of Treatment
☐ Psychological Evaluation(s) Reports
☐ Progress Review/Summary
☐ Medical History, Lab Results, Immunizations Records
☐ End of Agency Treatment
☐ Medications Prescribed
☐ Screening Assessment(s)
☐ Treatment Plan(s)

Other

Records Start Date		**Records End Date**	

Restrictions

Terms

I understand

- Under state and federal confidentiality provisions only the information specified can be released.
- The recipient(s) of my information may disclose it to others. I understand that in some cases, my information may no longer be subject to privacy law once it is disclosed.
- I may revoke this authorization at any time, but a revocation will not apply to information that has previously been released.
- If not otherwise specified, this authorization will expire in one (1) year from the date of signature.
- This authorization is voluntary, and that declining to sign this authorization will not impact my ability to get medical care, health insurance, or any government benefits. I have been given the change to ask questions and receive answers pertaining to this document.
- I have a right to a copy of this form.

Signing for a child. I understand that if I am signing this form on behalf of a minor, I should include my name as the “Legal Representative” of my child, and that I should sign this form. If my child is 12 or older, my child should also sign.

By signing, I authorize the disclosure as described above.

Agency Contact Information

Program					
Attention					
Address					
City		State		Zip	
Phone					

Other

Copy Given to Client? ☐ Yes ☐ Declined a copy

Agency Staff: _____

ID Verified By: ☐ Driver’s License ☐ Other Picture ID ☐ Known to Agency

Information about HIV/AIDs and Substance Abuse Treatment

Information about HIV/AIDs status and treatment for Substance Abuse will not be released without your specific permission. Do you authorize these releases of information to the person / organization listed above?

Alcohol/Drug Abuse:
☐ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.
☐ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDs/Sexually Transmitted Disease/Communicable Disease
☐ I authorize the release of information relating to HIV/AIDs/sexually transmitted disease/communicable disease.
☐ I **PROHIBIT** the release of information relating to HIV/AIDs/sexually transmitted disease/communicable disease.

Client Signature		**Date**	
Client Printed Name			

Parent/Guardian Signature		**Date**	
Parent/Guardian Printed Name			

Staff Signature		**Date**	
Staff Printed Name			